Utah Specific Transaction Instructions

837 Health Care Claim: Institutional (LTC)
ASCX12N 837 (004010X096A1)

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI ASC X12N Version 4010 implementation guides have been established as the standard of compliance. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N 837 (004010X096A1), Health Care Claim: Institutional, for long term care claims processing. Further billing instructions and policy are published in the Utah Medicaid Provider Manuals and the Utah Uniform Billing Instruction Manual.

Special Notes

1) A Utah Medicaid EDI enrollment form must be completed for each provider number. Transactions submitted without a valid EDI enrollment will be rejected and cannot be acknowledged.

2) 837I claims may be sent anytime 24 hours a day, 7 days a week. Transactions sent after close of business (COB) on Thursday will not be included in the following week's remittance.

3) When an 837I requests an acknowledgement ("1" in the ISA14 sub element) the Medicaid computer automatically generates two reports:

   a) A 997 Functional Acknowledgement (available for pickup within 2 hours).
   b) A 277 Health Care Claim Status Notification - Front End Acknowledgement (available for pickup within 48 hours).

4) Currently, Utah Medicaid accepts monthly billing, unless discharged. Charges may be billed at the time of discharge (claim must specify discharge date).

5) Not every field of the TAD translates into a field in the 837I. Some data is gathered from other sources, while other data is calculated.

Page	Loop	Segment	Data Element	Values / Comments	UB-Box	TAD Box
59		BHT06	Claim or Encounter Identifier	"CH"		
63	1000A	NM109	Submitter Identifier	UHIN Trading Partner Number		
68	1000B	NM103	Receiver Name	"Utah Medicaid FFS" OR "Utah Medicaid Crossover"		
68	1000B	NM109	Receiver Primary Identifier	"HT000004-001" OR "HT000004-005"		
83	2010AA	REF01	Reference Identification Qualifier	"1D"	51 (A-C)	
84	2010AA	REF02	Billing Provider Additional Identifier	Use the 12-digit identifier assigned by Utah Medicaid.	51 (A-C)	31
100	2000B	HL04	Hierarchical Child Code	"0" - The subscriber is always the patient, there are no dependents in Utah Medicaid.		
105	2000B	SBR09	Claim Filing Indicator Code	"MC"		
109	2010BA	NM102	Entity Type Qualifier	"1"		
109	2010BA	NM103	Subscriber Last Name	Patient's last name. Dashes and spaces not allowed.	58 (A-C)	3
109	2010BA	NM104	Subscriber First Name	Patient's first name. Dashes and spaces not allowed.	58 (A-C)	3
109	2010BA	NM105	Subscriber Middle Name	Patient's middle name. Dashes and spaces not allowed.	58 (A-C)	3
110	2010BA	NM108	Identification Code Qualifier	"MI"		
110	2010BA	NM109	Subscriber Primary Identifier	Use the 10-digit identifier assigned by Utah Medicaid. Do not submit hyphens or spaces.	60 (A-C)	2
127	2010BC	NM103	Payer Name	"Utah Medicaid FFS" OR "Utah Medicaid Crossover"	50(A-C)	
128	2010BC	NM109	Payer Identifier	"HT000004-001" OR "HT000004-005"		
139	2000C	HL	Patient Hierarchical Level	The subscriber is always the patient in Utah Medicaid. It is not necessary to complete this loop.		

Page	Loop	Segment	Data Element	Values / Comments	UB-Box	TAD Box
158	2300	CLM01	Patient Account Number	Unique number created by provider to link 277FE and 835 data to this claim. NOTE: This number must be unique to the claim to work properly.	3	
159	2300	CLM02	Total Claim Charges	Total Claim Charges	47	8
159	2300	CLM05-1	Facility Type Code	Acceptable codes: “18", “21", “22", “23", “25", “26", “28", “65", “66", “68"	4 (1-2)	
159	2300	CLM05-3	Claim Frequency Code	Acceptable codes: “1", “2", “3", “4", “7”, or “8”	4 (3)	
166	2300	DTP03	Discharge Hour	Report discharge hour.	21	
168	2300	DTP03	Statement From or To Date	Statement date	6 (from & through)	6 & 7
170	2300	DPT03	Admission Date and Hour	Date of admission and hour	17 &18	
171	2300	CL101	Admission Date and Hour	Type of Admission	19	
172	2300	CL102	Admission Source Code	Source of Admission	20	
172	2300	CL103	Patient Status Code	Discharge patient status.	22	
179	2300	AMT02	Estimated Claim Due Amount	Net claim charge.	55 (A-C)	11
181	2300	AMT02	Patient Responsibility Amount	Report patient responsibility listed by another payer after a third party payment.	55 (A-C)	
192	2300	REF02	Claim Original Reference Number	When codes “7" or “8" are submitted in 2300 CLM05-3, the Transaction Control Number (TCN) assigned to the original claim must be reported.	37 (A-C)	
198	2300	REF01	Reference Identification Qualifier	“G1" for pre-admission (10A) or for prior authorization. Medicaid does not use referral numbers.		
199	2300	REF02	Prior Authorization or Referral Number	Use the 7 digit pre-admission (10A) or the prior authorization assigned by Medicaid.	63 (A-C)	12
205	2300	NTE	Claim Note	Provide necessary claim information.		

Page	Loop	Segment	Data Element	Values / Comments	UB-Box	TAD Box
228	2300	HI01-2	Principal Diagnosis	List primary diagnosis.	67	
228	2300	HI02-2	Admitting Diagnosis	List admitting diagnosis.	76	
233	2300	HI01-2	Other Diagnosis	List any additional diagnosis.	68 THRU 75	27
257	2300	HI01-2	Occurrence Span Codes	To report Therapy Leave Days/Leave of Absence, use "74"	36 (a-b) span code & dates	
257	2300	HI01-4	Occurrence Span Code Associated Date	Date range for Occurrence Span Code	36 (a-b) From and Through fields	
268	2300	HI01-2	Occurrence Code	"42" - Date of Discharge	32-35 (a-b)	
268	2300	HI01-4	Occurrence Code Associated Date	Date of Discharge	32-35 (a-b) Date field	26
281	2300	HI01-2	Value Code	To report family responsibility/liability, use "D3"	39-41 (a-d)	
281	2300	HI01-5	Monetary amount	Amount assigned by Medicaid as Family responsibility for covered days	39-41 (a-d)	9A
306	2300	QTY	Claim Quantity	Used to report covered and non-covered days	Covered 7 Non-cov 8 Coin 9 LRD 10	23
359	2320	SBR	Other Subscriber Information	If the patient has Medicare or other 3rd party coverage, repeat this loop for each payer. Do not put information about Utah Medicaid coverage/payment in this loop.		
367	2320	CAS02	Adjustment Reason Code	Report standard code as received on EOB.		
367	2320	CAS03	Adjustment Amount	Report amount relating to adjustment reason code.		
371	2320	AMT02	Payer Paid Amount	Report amount received from other payer.	54 (A-C)	9B

Page	Loop	Segment	Data Element	Values / Comments	UB-Box	TAD Box
372	2300	AMT02	Allowed Amount	Report allowed amount from any 3rd party payer.		
377	2300	AMT02	Medicare Paid Amount	For Medicare COB, report amount.		
415	2330B	DTP03	Adjudication or Payment Date	Report date claim paid by other payer.		
446	2400	SV201	Product/Service ID	Use appropriate REV codes for charges, therapy leave (0183), and hospital leave days, (0185)		
448	2400	SV204	Unit or basis for measurement	"DA" for days "UN" for units		
449	2400	SV205	Quantity	Number of days associated with charges or hospital/therapy leave days.		
490	2400	SVD	Service Line Adjudication Information	Use this loop if line level payment was received from another payer.		
491	2400	SVD02	Service Line Paid Amount	Report amount paid by other payer.		
496	2430	CAS02	Adjustment Reason Code	Report standard code as received on EOB. Use adjustment reason code "1" to report deductible amount and "2" to report coinsurance amount.		
496	2430	CAS03	Adjustment Amount	Report amount relating to adjustment reason code.		